359 Minot Ave, Auburn, ME 04210
Phone: 207-784-3700
Fax: 207-784-7992

OSTOMY ORDER FORM

Patient Name:_______________________________ DOB:__________ Phone #:____________________

Facility:____ Fax #:______________________________

Please include the *Patient Demographic Sheet* with this order form

**Patient progress notes to support medical necessity are required in order for insurance to approve claim*

Primary Diagnosis/ICD-10 Code: ☐ Colostomy (Z93.3) ☐ Ileostomy (Z93.2) ☐ Urostomy (Z93.6)
☐ Other:____

Length of Need: ☐ Lifetime ☐ Other:______________ **Frequency of Use:**____________________ **Refills:**__________
Patient Currently Being Seen by Home Health? ☐ Yes ☐ No

Products

MANUFACTURER	☐ Hollister ☐ Convatec ☐ Coloplast ☐ Genairex ☐ Other________________	
Please Choose Size and Type Where Necessary	**Item #**	**Qty**
☐ One Piece Pouch ☐ Closed ☐ Drainable		
☐ Two Piece Pouch ☐ Closed ☐ Drainable		
☐ Flange w/ Skin Barrier (to use with the Two Piece Pouch)		
☐ Skin Barrier ☐ Paste (2 oz) ☐ Wipes (Box of 25)		
☐ Skin Barrier Wafer		
☐ Tape 1” 2” 3” ☐ Paper ☐ Cloth ☐ Waterproof		
☐ Barrier Ring ☐ 2” ☐ 4”		
☐ Night Urinary Drainage Collector		
☐ Bedside Urinary Drainage Bag 2000cc		
Other:		

Additional Notes:____
____
____

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order, and I certify that the above prescribed supplies are medically necessary and reasonable.

Physician Name:____ **NPI #:**____________________

Phone Number:________________________________ **Fax Number:**____________________________

Physician Signature:____ **Date:**____________

324.0